



MNsure Consumer Assistance Partner Application

1	Partnership Type Requested (check all that may apply): <input type="checkbox"/> In-Person Assister <input type="checkbox"/> Navigator <input type="checkbox"/> Certified Application Counselor	Office use only:
2	Legal Name of Organization	Legal Address of Organization
	Organization Phone Number	Fax Number
	Website / Hours of Operation	
	Federal Employer ID#	Minnesota Tax ID#
Organization Type: <input type="checkbox"/> Nonprofit <input type="checkbox"/> Health Plan <input type="checkbox"/> Coalition / collaborative <input type="checkbox"/> Association <input type="checkbox"/> Chamber of Commerce <input type="checkbox"/> Government Agency <input type="checkbox"/> Farming organization <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Other <input type="checkbox"/> Religious organization		
Is your organization a health insurance issuer, subsidiary of a health insurance issuer, or an organization that lobbies on behalf of the insurance industry? If yes, please provide brief context. Yes No		
Disclose any funding (public, private, direct or indirect) your agency currently receives to provide consumer assistance to individuals or households applying / enrolling in health insurance:		
3	Does your organization currently receive compensation directly or indirectly from a health insurance issuer or issuer of stop loss insurance? If yes, please provide brief context. Yes No	
	Is your organization a hospital based health care provider or is your organization paid by a hospital based health care provider to assist individuals or households applying / enrolling in health insurance? If yes, please provide brief context. Yes No	



4	List the targeted geographic area(s) your organization serves or will serve. Please be as specific as possible:		
	Describe the targeted populations and communities your organization serves or will serve:		
	Describe your partnerships and relationships with partners in the communities you serve or will serve:		
	Briefly describe how your organization will carry out the responsibilities of a Consumer Assistance Partner, including key strengths:		
	Does your organization currently provide consumer assistance to individuals or households applying / enrolling in health insurance? Yes No If yes, describe current activities, including locations if applicable.		
5	Estimated number of applications your organization will submit on a monthly basis:		
	Is your organization registered with the Minnesota Secretary of State? Yes No If so, please list the name under which your organization is registered (if different from above).		
	Primary Contact's Name	Primary Contact's Phone Number	Primary Contact's Email Address
	Contract Representative's Name	Contract Rep's Phone Number	Contract Rep's Email Address
	HIPAA Representative's Name	HIPAA Rep's Phone Number	HIPAA Rep's Email Address
If you have staff at multiple locations providing consumer assistance, please provide the requested information on the Multiple Locations Form - Appendix A.			



Appendix A: Multiple Locations

Legal Name of Organization – Location #1		Legal Address of Organization – Location #1	
Phone Number	Fax Number	Website / Hours of Operation	
Primary Contact's Name		Primary Contact's Phone Number	Primary Contact's Email Address

Legal Name of Organization – Location #2		Legal Address of Organization – Location #2	
Phone Number	Fax Number	Website / Hours of Operation	
Primary Contact's Name		Primary Contact's Phone Number	Primary Contact's Email Address

Legal Name of Organization – Location #3		Legal Address of Organization – Location #3	
Phone Number	Fax Number	Website / Hours of Operation	
Primary Contact's Name		Primary Contact's Phone Number	Primary Contact's Email Address

Legal Name of Organization – Location #4		Legal Address of Organization – Location #4	
Phone Number	Fax Number	Website / Hours of Operation	
Primary Contact's Name		Primary Contact's Phone Number	Primary Contact's Email Address